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RESIDENTIAL CARE FOR ELDERLY PEOPLE: POLICY IMPLICATIONS FROM AN EXPLORATORY STUDY

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Discussion Paper 1251
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Background

The Association of Directors of Social Services, in response to the Burgner review, has called for joint health and local-authority inspection of residential homes (*Community Care*, 8.1.97, p. 1). Yet there is little agreement about what constitutes good residential care (Gibbs and Sinclair, 1992). Without such information, we cannot make valid comparisons between homes or set meaningful standards. The study described below tested a wide range of possible measures of quality of care. It adopted an eclectic approach, including the perspectives of residents, health and social care professionals, home staff, managers, and relatives. Full details of the instruments used are given in the final report, which is available from the Personal Social Services Research Unit, University of Kent at Canterbury, CT2 7NF, as Discussion Paper 1245.

Profile of residents

We interviewed over 300 residents in 17 homes (9 local authority-run, 4 private and 4 voluntary). On average the homes had 29 residents, with a mean age of 85, 24 per cent of them male. Seventy-two per cent had a mobility problem, 40% had impaired hearing, and 46% had impaired vision. Seventy nine per cent had some dementia, and in 37% of residents this was severe. ***Residential care is frequently dementia care.***

Medication

On average, residents were taking 3 or 4 different medications, 47% were taking analgesics, 35% diuretics, 23% hypnotics, 19% major tranquillisers, and 18% anti-depressants. There was considerable variation between homes in the use of major tranquillisers (5%-28%) and hypnotics (0-38%), which could not be explained by variation in health needs. The use of sedative drugs for people with dementia can be a substitute for more labour-intensive psychosocial approaches, and 23% of people with dementia were prescribed major tranquillisers. ***The appropriate use of medication in homes is an issue for further investigation.***

Depression

Depression in elderly people impairs quality of life and can often be treated effectively. Of the 194 people who were able to respond to questions about depression, 40% were depressed, but only 30% of these people were receiving anti-depressant medication. In two homes, nobody was receiving anti-depressants at all even though at least 21% were depressed. Our findings concerning high levels of depression echo those made 20 years ago, indicating a lack of detection and treatment of this disorder. ***Brief instruments to screen residents for depression should be administered routinely in homes.***

Health needs and psychological well-being

We found that common health needs such as immobility, instability, hearing and visual impairment were not always recognised and treated. However, when these needs were met, residents had a significantly lower depression score than when physical needs were overlooked. ***Psychological well-being is closely associated with physical care.***

Inspectors ought to be able to assess prescribing patterns in the home, as well as the appropriateness of responses to physical and psychological needs. Our findings on the responses to common physical health problems, depression and use of medication indicate that ***Inspectorates should include health professionals.***

Documentation

While care plans cannot guarantee optimal responses to needs, they should help to ensure continuity and consistency between the large number of staff who work in each home. We evaluated care plans on four dimensions; physical, emotional, social and cultural, setting 26 weeks as the limit for a plan to count as being ‘up to date’. In general, the emotional and cultural needs of residents were given less attention than the social and physical needs. High standards of documentation were relatively rare. ***Audit or monitoring of care plans should form part of inspections and evaluations.***

Social, occupational and physical environment

Provision of opportunities for daily activities was found to be important to staff, relatives and residents. Yet only 23% of care plans referred to residents' social needs, and only one home had an activities organiser. The proportion of people participating in reading, socialising and domestic tasks was much lower than for elderly people aged 70 or over living in their own homes, although the level of disability in the latter group would be lower than for people in this study. ***The provision of activities, and especially occupational activities for people with dementia, will be critical to the quality of care in homes.***

Visitors' satisfaction

Visitors are usually well placed to judge the care being given. However, some homes might encourage constructive criticism from visitors, or visitors may feel reticence, fear of retribution affecting the resident, and guilt about the admission, thus it is difficult to obtain consistent data by counting critical comments. Most visitors to the home were the offspring of residents, and 68% had been the resident's former carer. Nearly half went to the home one or more times per week. ***The development of methods for eliciting visitors' knowledge about homes, would enhance assessments of quality of care.***

Staffing considerations

There was a five-fold variation in the staff-to-resident ratio for total staffing levels in the homes (0.11 - 0.58 for all staff; 0.05 - 0.25 for care assistants only). In the seventeen homes studied there were about 500 staff members, many working part-time, yet less than 1% had professional qualifications. In three homes no member of staff had any formal qualifications. The enormous task of training and retraining homes staff is facilitated by the system of National Vocational Qualifications. ***Any home which is not actively training staff must give cause for concern.***

Despite high levels of dependency in residents, few homes had senior staff with nursing qualifications. Proper preventive measures and rehabilitation of residents could postpone the need for nursing home care. ***There is an urgent requirement for health care training for homes staff.***

Costs

Capital, revenue and total costs per resident week were analysed for 1994-5, taking account of occupancy levels. The mean cost per week was £258 (range £184-442), but residents also received other services than those covered by the home's fees, notably hospital care, primary health services, professions allied to medicine, and social services. These add an average of £15 per resident week, making the mean cost of care £278 (range £206-468).

Local authority provision cost more than voluntary provision which cost more than private provision, a typical pattern. However, in privately-run homes higher additional service costs were incurred, attributable to the use of community health services. This may have implications for the local health service. ***The impact of residential homes on community and primary health care services may need to be taken into account in funding these services.***

Higher costs were associated with the provision of short term care. Three of the homes studied (all local authority-run) were increasing the levels of short term care. The average costs of these homes (excluding additional services) was £346 per week compared to £234 among other homes. ***Apparent savings from purchasing long-term care in the private sector may need to be offset by the increasing costs generated if local authorities retain short-term provision.***

Ranking analysis

We ranked the homes on 25 measures which were independent of each other and showed variation across the homes studied. Several homes performed consistently better. Low ranking homes are not less good in an absolute sense, but only relative to the high ranking homes. ***Homes which performed better on our indicators did not have significantly higher overall costs than those which performed less well.***

Conclusion

The study found that the role of visitors in monitoring care could be expanded, and the impact of residential homes on primary and community health services should be evaluated. further. Perhaps surprisingly, it found no associations between costs and quality. In such a small number of homes, this can only be taken as tentative finding, but it should generate optimism about the possibility of improving care within existing budgets.

Many of the policy implications are directly related to high levels of physical and mental dependency in homes, a situation which is likely to grow more burdensome as people are admitted only in extremis. High dependency demands greater awareness of health and psychological needs, close monitoring and consistency of care, specially adapted occupational activities, and specialist training of staff. Joint Inspectorates open the way to the utilisation of health expertise in residential care, but they do not guarantee the full participation of health professionals. This should be a prime consideration in any reorganisation of Inspection Units for residential and nursing homes.

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